

medical practice, possibly more common these days with so many potent and interacting drugs with some unfortunate side effects.

The urge for euthanasia is surely utilitarian. It saves time for doctors and relatives, and avoids the experience of failure when we can't cure. It may be that GP training needs to concentrate more on the value of life, and even the mysterious value of suffering. I well remember a patient with severe pain from gastric cancer, who refused all pain relief, as he wanted to 'be brave'. He was an agnostic and I doubt if he understood the value a Christian attaches to suffering, But he was an example to all who cared for him.

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Low carbohydrate diets for diabetes control

Fleming, Cross and Barley¹ are right to be concerned about the growing prevalence of type 2 diabetes in General Practice.

Despite the growing incidence of type 1 and 2 diabetes and the accelerating cost of the resources needed to monitor and treat these patients, we are obviously not succeeding in reducing either the number of people affected or the severity of the complications of these conditions.

Yet there is a simple, effective, low-cost strategy that is proven to work with diabetes: reduce the amount of sugar and starch in the diet.

This is backed up by rigorous scientific research and I have included a few of the more recent reviews concerning this subject below.^{2–4}

On a more personal note, my son became diabetic 18 months ago. His HbA1C is 5.1 and his insulin requirements have not increased since stabilisation after diagnosis. His blood sugars are rarely out of the 4–7.8 range even after meals on a

restricted carbohydrate diet. He rarely experiences hypoglycaemia and has had no severe events.

I have also encouraged my diabetic patients to try this way of eating for themselves. It is usual for patients with type 2 diabetes to experience a 2–3% drop in HbA1C after 3 months on a low carb diet. The impact on reducing complications and associated drug costs can be imagined.

The lower the carbohydrate consumed the less insulin is needed for type 1 diabetics and the less hard the pancreas has to work for type 2 diabetics. For example, insulin dependent diabetics can expect to half or third their insulin requirements. Less insulin injected results in more predictable blood sugars and less hypoglycaemia.

The medical establishment has been less than enthusiastic about adopting low carb diets. All of the usual gripes have been thoroughly debunked or can be dealt with by modifications to the diet. It is time to stop feeding patients a diet of junk science and start feeding them food that makes them well instead of sick.

You would think that Diabetes UK would be interested in promoting a diet that does all of these:

- prolongs honeymoon phase in type 1 diabetics;
- prolongs pancreatic function in type two diabetics;
- promotes a healthy weight;
- reduces need for insulin;
- reduces need for oral hypoglycaemic drugs;
- promotes high HDL and low triglycerides;
- Reduces hypoglycaemia;
- Reduces development of glucose intolerance to type two diabetes;
- optimises glycaemic control including post prandial blood sugars.

Sadly, Diabetes UK does not.

If health professionals or patients want to learn more about this I can recommend Dr Bernstein's *Diabetes solution*.⁵ Dr Richard Bernstein became an insulin-dependent diabetic when he was 12 years old and continues to practice as a physician dedicated to diabetes management at the age of 67. He was the

first patient to use a portable blood sugar monitor, and through careful self experimentation he managed to reverse most of his diabetic complications. He has developed a comprehensive educational course that turns normal patients into highly competent self carers with truly normal blood sugars round the clock.

How long can we as a profession afford to keep our heads in the sand regarding the benefits of low carb diets for diabetics?

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Breakdown in communication

While I feel that Mike Fitzpatrick does set out to be deliberately provocative I cannot let his September offering on communication skills go without comment. I cannot claim to write for all the communication skills educators throughout the world but the negative tenor of this article certainly dismisses part of what I do for a living.

Certainly we know that there are still problems with the way that doctors communicate with patients. The fact that communication training is being extended into the postgraduate years is a good thing and does not provide evidence that undergraduate communication skills experience is failing to meet its objectives. However Dr Fitzpatrick cannot have it both ways: that doctors' communication is not